Please bring this form to your appointment

RETINA & VITREOUS CONSULTANTS OF WI, LTD

PATIENT INFORMATION:

Last Name_____First Name_____Middle___

Address_____

City _____State_____ ZIP_____

Home Phone (_____) _____ Cell Phone: (_____) _____

Social Security # _____-_____-_____ Sex: ❒ Male ❒ Female Age: _____

Date of Birth: _____ E-Mail: _____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other

Race: ❒ White/Caucasian ❒ African American ❒ Other _____

Language Spoken: ❑ English ❑ Hmong ❑ Spanish ❑ Russian ❑ Other: _____

Ethnicity: ❒ Hispanic ❒ Non-Hispanic Social Security # _____-_____-_____

❑ Retired ❑ Employed/Employer: _____

Occupation: _____ Work Phone: (_____)_____

How would you like to be contacted: ❑ Home Phone ❑ Cell Phone ❑ Other _____

Referring Ophthalmologist/Optometrist:_____Phone_____

Primary Care/ Family Doctor:_____ Phone_____

Primary Care Doctor Address: _____

Diabetic Status: ❑Non-Diabetic ❑Non-Insulin Dependent ❑ Insulin Dependent

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WORKERS COMPENSATION INFORMATION Will this be covered under Workers Comp Ins.? ❒ No ❒ Yes If Yes: Accident Date: _____

Company Name_____Phone# (_____) _____

Company Address_____

City/St/Zip_____

WC Claim #: _____ Treatment Authorized by_____

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EMERGENCY CONTACT INFORMATION: Please list the Nearest Friend or Relative ***not*** living in the same household with you:

Name_____Phone(_____)_____
Relationship to Patient_____

RESPONSIBLE PARTY (*if different from patient*):

Last Name_____First Name_____Middle___

Address_____

City _____State_____ ZIP_____

Home Phone (_____) _____ Cell Phone: (_____) _____

PRIMARY INSURANCE INFORMATION:
Insurance Company_____
Policy Number _____
Subscriber Name _____ Sex: ❑ Male ❑ Female
Subscriber Date of Birth ____/_____/_____Subscriber SS#_____
How are you related to the Policy Holder:
❑ Self ❑ Spouse ❑ Partner ❑ Mother ❑ Father ❑ Child ❑ _____

Employment Status: ❑ Retired ❑ Employed If employed please fill out below
Subscriber's Employer Name _____
Employer's Address:_____
City _____ State _____ Zip _____ Work Phone _____
Does this Policy require a Referral? ❑Yes ❑No ❑Unknown

SECONDARY INSURANCE INFORMATION:
Insurance Company_____
Policy Number _____
Subscriber Name _____ Sex: ❑ Male ❑ Female
Subscriber Date of Birth ____/_____/_____Subscriber SS#_____
How are you related to the Policy Holder:
❑ Self ❑ Spouse ❑ Partner ❑ Mother ❑ Father ❑ Child ❑ _____

Employment Status: ❑ Retired ❑ Employed If employed please fill out below
Subscriber's Employer Name _____
Employer's Address:_____
City _____ State _____ Zip _____ Work Phone _____
Does this Policy require a Referral? ❑Yes ❑No ❑Unknown

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TO OUR PATIENTS:

Retina & Vitreous Consultants of Wisconsin, Ltd., accepts assignment as participating providers in the Medicare Program. We will file claims to your primary and secondary insurance for you, if you provide us with that information. Please feel free to speak with someone in the business office if you have further questions regarding our billing practices.

PATIENT AUTHORIZATION:

1. **RELEASE OF INFORMATION**: I hereby give my consent to Retina & Vitreous Consultants of Wisconsin, Ltd., to release any information regarding my care and treatment as may be required by any insurance carrier in connection with payment by the insurance carrier of any portion of my bill.

2. **RELEASE OF MEDICAL RECORDS**: I hereby give my consent to Retina & Vitreous Consultants of Wisconsin, Ltd., to release duplicate or fax copies of medical Records regarding my care and treatment to authorized Doctors, Clinics, Myself, or Persons I Deem to receive such records. I understand this may be revoked at any time by providing my written revocation. I understand that I have the right to review Retina & Vitreous Consultants of Wisconsin, Ltd's **NOTICE OF PRIVACY PRACTICES**, which describes how medical information about me may be used and disclosed, and acknowledge receiving a copy of the Notice from Retina & Vitreous Consultants of Wisconsin, Ltd., with this packet unless I have received a copy of it previously.

3. **RESPONSIBILTY FOR PAYMENT / PATIENT AGREEMENT**: I understand that the physician(s) practicing under the name of Retina & Vitreous Consultants of Wisconsin, Ltd., are in no way bound by fee schedules or other guidelines published by any insurance company, government agency, etc. I agree to pay any portion of the fees charged to me that are not covered by my insurance company in the event full coverage is not afforded me or if I do not have the necessary coverage.

4. **ASSIGNMENT OF BENEFITS**: I hereby authorize payment to be rendered directly to Retina & Vitreous Consultants of Wisconsin, Ltd., for the benefits otherwise payable to me by any third party.

5. **TEXT MESSAGES AND EMAILS:** I understand that Retina & Vitreous Consultants of Wisconsin, Ltd. may send text messages and emails as a mode of communication for appointment reminders, patient feedback or updates.
   If you choose to opt out of receiving texts and emails, please indicate here by checking the box.
   ☐ I do not want to receive text messages or emails.

_____ _____

Patient, Guardian or POA Signature Date

Front Desk: Please input the following:

Patient Name: _____ ***Chart Number:*** _____

RETINA & VITREOUS CONSULTANTS OF WI, LTD
Additional Release(s) of Medical Information and Medical Records to Designated Persons.

In addition to the above consents for release of information, I authorize Retina & Vitreous Consultants of Wisconsin, Ltd., to release records and information regarding my health to the designated person(s) listed below. I understand the additional release(s) may be revoked at any time by providing my written revocation.

Person To Release to: (Name) _____

_____

Relationship (Optional) Phone Number with Area Code (Optional)

Type of Information to be released: (Check All That Apply)

___ Medical History ____ Lab Reports ____ Surgical Reports ____ Test Results
___ Doctor's notes ____ Billing/Statement Information ____ All of the Above

This authorization expires on _____/_____/_____ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

Person To Release to: (Name) _____

_____

Relationship (Optional) Phone Number with Area Code (Optional)

Type of Information to be released: (Check All That Apply)

___ Medical History ____ Lab Reports ____ Surgical Reports ____ Test Results
___ Doctor's notes ____ Billing/Statement Information ____ All of the Above

This authorization expires on _____/_____/_____ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

_____ _____

Signature of Patient, Legal Guardian or Power of Attorney Date

You may request additional release(s) of medical information and medical 1records forms from the front desk.

Witnessed by: _____